

Social Security Administration

**Social Security Administration**

**Request for Verification of Hospital Insurance (HI) Payments**

CMS, OIS, DSS-CWF  
Attn: R.W. N2-13-16  
7500 Security Blvd.  
Baltimore, MD 21244

Office Address:

Date:

Social Security Number/BIC:

Claimant's Name:

We have received a request for withdrawal of the HI claim. Please determine whether any Part A (HI) payments have been made and furnish the period(s) and amount **or** indicate that payments have not been made in the spaces provided on the bottom portion of this form. A self-addressed envelope is enclosed for return of the completed form to the appropriate office.

\_\_\_\_\_  
Name of Requestor

(    )  
\_\_\_\_\_  
Telephone Number of Requestor

Enclosure:  
Return Envelope

**To Be Completed by the Centers for Medicare and Medicaid Services (CMS)**

Period(s) of Payment:

Amount:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\$ \_\_\_\_\_  
\$ \_\_\_\_\_  
\$ \_\_\_\_\_

\_\_\_\_\_ No HI payments have been made to the claimant as of the date shown below.

Initials: \_\_\_\_\_  
CMS Program Analyst

Date: \_\_\_\_\_